STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

OMNICARE HEALTH PLAN, INC.

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2003,
THROUGH MARCH 31, 2003

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FROM: Gregory L. Hawkins, CPA, TennCare Examinations Manager
Glen Hughes, CPA, TennCare Examiner
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DATE: May 24, 2004

A Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of OmniCare Health Plan, Inc., Memphis, Tennessee, was completed October 23, 2003. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of OmniCare Health Plan, Inc. ("OmniCare"). Further, this report reflects the results of a limited scope examination of the financial statement account balances as reported by OmniCare. This report also reflects the results of a compliance examination of OmniCare's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of OmniCare was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of section 3-6. of the Contractor Risk Agreement between the State of Tennessee and OmniCare, Executive Order No. 1 dated January 26, 1995, and § 56-32-215 of the Tennessee Code Annotated (Tenn. Code Ann.).

OmniCare is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of OmniCare. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by OmniCare on its National Association of Insurance Commissioners (NAIC) quarterly statement for the quarter ended March 31, 2003, and the Medical Fund Target Report filed by OmniCare as of July 31, 2003.

The limited scope compliance examination focused on OmniCare's provider appeals procedures, provider agreements and subcontracts; the demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act and the Insurance Holding Company Act.

Fieldwork was performed using records provided by OmniCare before the onsite examination and during the onsite examination from September 15 through September 25, 2003. Also, fieldwork was performed during an onsite examination of OmniCare's claims processing subcontractor from October 20, 2003, through October 23, 2003.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that OmniCare's operations were administered in accordance with the Contractor Risk Agreement, and state statutes and regulations concerning HMO operations, thus reasonably assuring that the OmniCare TennCare members received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether OmniCare met its contractual obligations under the Contractor Risk Agreement and whether OmniCare was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;

- Determine whether OmniCare had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its members on an ongoing basis;

- Determine whether OmniCare properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether OmniCare had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether OmniCare had corrected deficiencies outlined in the prior examination conducted by TDCI.

III. PROFILE

A. Administrative Organization

OmniCare Health Plan, Inc., formerly Affordable HealthCare Corporation, was chartered in the State of Tennessee on October 6, 1993, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program. The Amended and Restated Bylaws of OmniCare, dated March 14, 1995, provided that the business will be conducted using the name OmniCare Health Plan, Inc. United America of Tennessee (UA-TN) is the majority owner of OmniCare. OmniCare contracts with UA-TN to provide management services.

The officers and board of directors for OmniCare at March 31, 2003, were as follows:

Officers for OmniCare

Osbie Howard, President
Lorenzo Harris, Treasurer
Marsha Lynn Robinson, Secretary

Board of Directors for OmniCare

Alvin King	Julius Combs, M.D.
Rebecca Clark	Samuel King
William Brooks	Frank Banks
Beverly Williams-Cleaves, M.D.	Thomas J. Marzette
Charles Carpenter	Osbie Howard
Marsha Lynn Robinson	

B. Brief Overview

On January 3, 1994, OmniCare contracted with the state as a preferred provider organization. On March 3, 1996, TDCI issued OmniCare a certificate of authority to operate as an HMO.

Effective July 1, 2002, the Contractor Risk Agreement with OmniCare was amended to temporarily operate under a non-risk agreement from July 1, 2002, through December 31, 2003. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a

managed care environment for enrollees and assist the Bureau of TennCare in restructuring the program design to better serve Tennesseans adequately and responsibly. OmniCare agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002.

During the period under examination, OmniCare was licensed by TDCI and the TennCare Bureau to participate in the TennCare program in the West Tennessee Grand Region. OmniCare derives the majority of its revenue from payments from the state for providing medical benefits to TennCare members. As of March 31, 2003, OmniCare had approximately 112,250 TennCare members.

C. Claims Processing Not Performed by OmniCare

During the period under examination, OmniCare subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Scripts Pharmacy Solutions, Inc., for pharmacy claims processing,
- Doral Medical USA, LLC (Doral) claims processing, and
- Block Vision for vision services.

Only the medical claims processed by Doral were included in the pool of claims from which claims were selected for detailed testing. Therefore, except for timeliness testing of pharmacy claims, no pharmacy or vision claims were tested as part of the examination. It should be noted that as of July 1, 2003, OmniCare was contractually no longer responsible for pharmacy benefits. The TennCare Bureau contracted directly with a single pharmacy benefits manager as of July 1, 2003, for the provision of pharmacy benefits to all TennCare enrollees.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are set forth for informational purposes. The following were financial and claims processing deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period April 1, 2000, through June 30, 2000:

A. Limited Scope Financial Examination

1. OmniCare's originally submitted NAIC Statement for the Quarter Ended June 30, 2000 understated claims payable by $811,661. The understatement resulted in a statutory net worth deficiency of $679,608 for June 30, 2000. UA-TN purchased $900,000 preferred stock in OmniCare to fund the statutory net worth deficiency.

2. The medical loss ratio reports filed through September 30, 2000, revealed several discrepancies. The incurred but not reported (IBNR) component of the medical loss ratio report was not based on actuarial studies or previous historical payment patterns of medical claims. Administrative costs of $23,500 related to the claims processing fee of a pharmacy subcontractor was improperly included in the medical loss ratio report as medical expenses. Drug payments of $90,407 related to dates of service prior to July 1, 2000 were improperly included in the medical loss ratio report as medical expenses.

3. Subsequent to the examination period, OmniCare failed to notify TDCI that it had amended the management agreement with UA-TN. The amended management agreement is a modification of its certificate of authority and requires the prior approval of TDCI.

4. OmniCare incorrectly reported $252,222 in funds held in escrow by providers as an admitted asset. Under NAIC guidelines funds held in escrow are not readily available for the payment of claims and therefore should be classified as non-admitted assets.

5. Support for collection of $295,954 in accounts receivable due from providers was not provided and has been adjusted from net worth.

6. Premium revenues as of June 30, 2000, incorrectly includes amounts improperly accrued in premium revenue for the year ended December 31, 1999, that were never collected. Premium revenues of $6,200 have been adjusted from net worth.

The deficiencies numbered above as 1 and 3 are repeated as part of this report. The other deficiencies noted above were corrected and thus not repeated in this report.

B. Claims Processing

1. The data file provided by OmniCare could not be reconciled to the general ledger to within an acceptable limit.

2. OmniCare did not process claims in accordance with the TennCare contract. Ninety-six percent of all claims tested were processed within 60 days. The TennCare contract requires an MCO to process 100% of all claims within 60 days.

3. One of the 50 claims tested contained incorrect or missing data elements.

4. Three of the 50 claims tested were improperly denied.

5. OmniCare paid incorrect amounts for two of the 50 claims tested.

6. One claim was correctly denied, however; OmniCare's claims system indicated a paid amount.

7. The Claims Status Report submitted to TennCare on a weekly basis is not prepared correctly.

The deficiencies numbered above as 3 and 5 are repeated as part of this report. The other deficiencies noted above were corrected and thus not repeated in this report.

V. SUMMARY OF CURRENT PERTINENT FACTUAL FINDINGS

The summary of current factual findings are set forth below. The details of testing as well as managements comment to each finding can be found in Sections VI, VII and VIII of this examination report.

A. Financial Deficiencies

1. OmniCare did not submit for required approval by TDCI modifications to the management agreement between OmniCare and its parent company United America of Tennessee, Inc., before the modifications were implemented.
(See Section VI.A.4.)

2. OmniCare incorrectly reported as an admitted asset receivables which exceeded 90 days old as of the sworn submission date on the March 31, 2003, NAIC Quarterly Financial Statements. The misstatement of the financial statements was the result of OmniCare's failure to abide by the terms of Letter of Agreements with two medical

providers. Subsequently, the receivables were collected which negated a required adjustment to net worth.
(See Section VI.A.2.)

3. OmniCare's claims unpaid as reported on the March 31, 2003, NAIC Quarterly Financial Statement was understated by at least $318,279. The understatement of claims unpaid did not affect OmniCare's net worth as of March 31, 2003.
(See Section VI.A.5.)

4. OmniCare's Supplemental TennCare Operations Statement for the three months ending March 31, 2003, was not prepared as if OmniCare were still at risk by including all income and expenses related to claims, losses, and premiums for claims as required by section 2-10.i. of the Contractor Risk Agreement.
(See Section VI.B.)

B. Claims Processing Deficiencies

1. The following deficiencies were noted during the review of the claims payment accuracy report preparation procedures:
(See Section VII.C.2.)

   - The Claims Payment Accuracy report prepared by OmniCare's claims processing subcontractor was not verified by OmniCare for accuracy.

   - Pharmacy claims processed by Scripts Pharmacy Solutions, Inc. and vision claims process by Block Vision were not included in the determination of the claims accuracy percentage.

   - Documentation was not maintained supporting the random selection of claims. As a result, the examiners could not verify that the claims tested were randomly selected as required in the section 2-9. of the Contractor Risk Agreement.

   - Documentation was not maintained supporting that the total claims population was defined before the claims tested were selected.

2. The procedure code reported on one claim tested did not agree with the procedure code entered in the claims system resulting in the incorrect reporting of encounter data to the TennCare Bureau and resulting in the incorrect payment of the claim.
(See Section VII.G.1.)

3. Two claims on the second submission by the provider were incorrectly denied due to untimely filing. The claims were originally submitted within the 120 day timely filing limit. Subsequently, OmniCare paid the claims based on provider appeals. (See Section VII.F.)

4. The fee table loaded in the claims processing system was incorrect for four claims tested resulting in incorrect payments to providers.
(See Section VII.G.2.)

C. Compliance Deficiencies

1. As of the end of the examination fieldwork, OmniCare contracted with five hospitals through a "Letter of Agreement" versus the required provider contract templates approved by TDCI. The Letter of Agreement is deficient in 36 of the required 44 minimum contract language requirements of section 2-18. of the Contractor Risk Agreement. Operation by OmniCare under the Letter of Agreement is in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. Subsequently on February 24, 2004, OmniCare amended the "Letter of Agreement" to correct the deficiencies noted in the examination.
(See Section VIII.C.1.)

2. OmniCare lacks an internal audit function as part of OmniCare's organization structure.
(See Section VIII.H.)

3. OmniCare's needs to improve the monitoring efforts of its major subcontractor for claims processing services.
(See Section VIII.I.)

4. For the 20 provider complaints selected for testing, 13 (65%) were not responded to within 30 days after the receipt of the complaint per Tenn. Code Ann. § 56-32-226(b)(3)(A).
(See Section VIII.A.)

5. Two provider contracts selected for testing did not include all provisions required by section 2-18. of the Contractor Risk Agreement.

(See Section VIII.C.2.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, OmniCare is required to file annual and quarterly statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if OmniCare meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At March 31, 2003, OmniCare reported $9,308,908 in admitted assets, $2,247,899 in liabilities and $7,061,008 in capital and surplus on its NAIC quarterly statement. OmniCare reported total net income of $108,867 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires OmniCare to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are included in the calculation of net worth and deposit requirements.

2003 Net Worth Calculation

OmniCare's premium revenue per documentation obtained from the TennCare Bureau totaled $185,140,877.91 for the calendar year 2002; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), OmniCare's current minimum statutory net worth requirement is $6,527,113. OmniCare reported total capital and surplus of $7,061,008 as March 31, 2003, which is $533,895 in excess of the minimum statutory net worth requirement.

Premium Revenue for the Examination Period

For the examination period January 1 through March 31, 2003, the following is a summary of OmniCare's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from the TennCare Bureau for the period January 1 through March 31, 2003	$3,416,691
Reimbursement for medical payments from the TennCare Bureau for the period January 1 through March 31, 2003	48,262,399
Reimbursement for premium tax payments from the TennCare Bureau for the period January 1 through March 31, 2003	1,209,520
Prior year capitation payments from the TennCare Bureau received during the period January 1 through March 31, 2003	776,671
Total premium revenue January 1 through March 31, 2003	$53,665,281

2. Health Care Receivables

OmniCare incorrectly reported as an admitted asset, receivables which exceeded 90 days old as of the sworn submission date on the March 31, 2003, NAIC Quarterly Financial Statement. The misstatement of the financial statements was the result of OmniCare's failure to abide by the terms of Letter of Agreements with two medical providers. By Letter of Agreement, OmniCare is required to deposit in these two providers' bank accounts a total of $1,050,000 at the beginning of the calendar quarter as assurance that OmniCare will process the providers' claims timely. In turn the providers are required to refund the $1,050,000 deposit plus interest to OmniCare at the end of the calendar quarter. These deposit and refund transactions are completed

each quarter in order to comply with statutory principles. During the examination it was determined that OmniCare did not comply with the Letter of Agreements with these providers because the above transactions did not occur for the quarter ending March 31, 2003. On the sworn submission date of May 30, 2003, for the March 30, 2003, NAIC Quarterly Statement, OmniCare should have been aware the receivable was 150 days old and therefore should have reported the receivable as a non-admitted asset. Per Tenn. Code Ann. § 56-32-212(a)(5)(D) admitted assets include receivables that are not more than ninety days past due. Subsequently, on September 2, 2003, the receivables were collected which negated a required adjustment to current net worth as of the issue date of this report.

Management's Comment:

OCHP concurs with this statement and made arrangements with the local bank where the funds are maintained to collect the receivable along with interest every ninety days. The receivable was then to be reestablished to satisfy statutory principles. The bank employee responsible for this process retired during this period and the necessary transactions did not take place. There was no evidence of this failure since month end balances were correct. The bank has initiated procedures to insure proper fund transfers in the future and OCHP will request verification that the appropriate transactions were recorded.

3. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and § 56-32-212(b)(3) requires all HMOs licensed in the state to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan."

Based upon premium revenues for calendar year 2002 totaling $185,140,877.91, OmniCare's statutory deposit requirement at March 31, 2003, is $2,150,000. OmniCare has provided TDCI with safekeeping receipts documenting that deposits totaling $2,150,000 have been pledged for the protection of TennCare enrollees.

4. Management Fee

OmniCare contracts with its parent company UA-TN to provide management services. Effective June 2001, the management fee paid to UA-TN was 10% of the TennCare revenues plus 100% of interest earned on investment income. As previously noted effective July 1, 2002, the Contractor Risk Agreement between OmniCare and the TennCare Bureau was amended to a non-risk contract. Instead of monthly capitation paid to OmniCare for medical and administrative services, OmniCare is paid a fixed administrative fee and reimbursed for medical costs of the enrollees. During the examination, it was determined that OmniCare modified the management fee paid to UA-TN to 80% of the fixed monthly administrative fee paid by the State of Tennessee plus 100% of any variable administrative fee expenses. The modification to the management agreement was effective from July 1, 2002, through February 2003. This represented a material modification of OmniCare's Certificate of Authority (COA) pursuant to Tenn. Code Ann. § 56-32-203(c)(1) but it was never submitted to TDCI for approval. This material modification to OmniCare's COA should have been submitted for prior approval by TDCI before the modification was implemented.

Also, during the examination, it was discovered that during February 2003, OmniCare adjusted the management fee from 80% to 90% retroactively for the period July 2002, through February 2003, and continued the change for all following months. Again, this represented a material modification of OmniCare's Certificate of Authority (COA) pursuant to Tenn. Code Ann. § 56-32-203(c)(1). Eventually on September 10, 2003, OmniCare submitted a request to change the management fee from 80% to 90% as a material modifications to OmniCare's Certificate of Authority. On September 12, 2003, TDCI issued a Notice of Filing Deficiency related to the request because the change in management fee lacked the required approval of the TennCare Bureau of the Tennessee Department of Finance and Administration. This unapproved material modification to OmniCare's COA should have been submitted for approval by TDCI before the modification was executed on February 18, 2003. As previously noted, this finding has been repeated from the previous examination. OmniCare should develop policies and procedures that will ensure that any material modifications are properly submitted for approval by TDCI as required by Tenn. Code Ann. § 56-32-203(c)(1).

Management's Comment:

OCHP does not concur with this statement. OCHP filed the proper requests for Material Modifications to our COA for the adjustments to the management fees, with no response from TDCI. When OCHP and the TennCare Bureau entered into a non-risk contract effective July 1, 2002, OCHP had an approved management agreement with UATN, which required payment of 10% of TennCare revenues plus 100% of interest. For the months of July and August 2002, OCHP was paid as if it was still at risk with TennCare payments in excess of $15million monthly. Since the ASO rate structure had not been finalized by TennCare, it was difficult, if not impossible for OCHP to determine its revenue and what could be paid as a management fee. The decision was made to wait until this information was available. While there is some disagreement as to when OCHP made a formal request to amend the management agreement, we know that it was submitted promptly. OCHP subsequently submitted another amendment to the State. We discussed this issue in detail with the auditors during their fieldwork and presented them with analysis and projections, which they agreed clearly supported payment of a management fee based upon either of the amended requests. The second delay (September 03) in OCHP submitting an amendment to the approved management agreement was due to a lack of receipt of the necessary financial information from the TennCare Bureau to determine the amount of funds, which could be paid to UATN to cover the operational cost of OCHP and not create net worth problems.

In the past, retroactive adjustments have been necessary, which have for the most part reduced OCHP's management fee payments to UATN. The primary reasons for the modifications have been to adjust for claims cost overruns. Despite the best efforts of OCHP and its actuaries to project their impact on operations, during the at-risk period, claims costs have required a disproportionate share of the premium paid by TennCare, which made it difficult for OCHP to remain viable. This has necessitated retroactive requests for amendments to its management agreement and additional capital contributions by UATN.

TDCI's and Comptroller's Rebuttal:

As previously stated, the modifications of the management agreement effective July 2002 and the subsequent retroactive change in February 2003 were not submitted to TDCI for prior approval before implementation by OmniCare as required by Tenn. Code Ann. § 56-32-203(c)(1). TDCI received the request for approval on September 12, 2003, for the management agreement that had already been implemented by OmniCare. On the same date of receipt, TDCI issued a Notice of Filing Deficiency related to the request because the change in management agreement

lacked the required approval of the TennCare Bureau of the Tennessee Department of Finance and Administration.

5. Claims Payable

As of March 31, 2003, OmniCare reported $396,386 in claims unpaid on the NAIC quarterly statement. This amount represented an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending June 30, 2002. Review of claims processing system payments after March 31, 2003, through August 31, 2003, for dates of services before July 1, 2002, indicates actual payments of $741,665. Therefore, OmniCare's claims unpaid as reported on the March 31, 2003, NAIC Quarterly Financial Statement was understated by at least $318,279 ($714,665 - $396,386). OmniCare should develop appropriate procedures which correctly estimates claims unpaid. The understatement of claims unpaid did not affect OmniCare's net worth as of March 31, 2003.

Management's Comment:

OCHP does not concur with this statement and disagrees with the results of this finding indicating that the NAIC Quarterly financial statements were understated by $318,279. Per the audit report, this understated represents claims for the period that OCHP was at risk, which extended through June 30, 2002. What the audit does not take into consideration is a Memorandum of Understanding executed in October 2002 between OCHP and the Department of Finance and Administration in which the State accepts liability for these claims. If the additional $318,279 claims liability had been recorded at March 31, 2003, it would have required the recognition of the same amount of revenue from the State.

Moreover, it should be noted that when the auditors visited in October 2003 they had the benefit of the passage of time. It was easy to look back at estimates that were recorded in March 2003 and realize that they were understated. The March 2003 estimates were based upon calculations by an outside actuary. They used their review of payment history, open claims and all other data available to arrive at their balances.

TDCI's and Comptroller's Rebuttal:

The Memorandum of Understanding between OmniCare and the Department of Finance and Administration does not permit the understatement of claims payable.

Furthermore, Statutory Accounting Principles requires liabilities to be reported by using the concept of conservatism. The concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory accounting.

B. Administrative Services Only (ASO)

As previously mentioned, effective July 1, 2002, OmniCare's Contractor Risk Agreement was amended so that OmniCare would operate in a non-risk manner or as an ASO until December 31, 2003. Under the NAIC guidelines for an ASO, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for claims with dates of service after June 30, 2002.

It should be noted that the Contractor Risk Agreement requires a deviation from ASO guidelines. The required submission of the supplemental TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if OmniCare were still operating at-risk. Section 2-10.i. of the Contractor Risk Agreement requires OmniCare to provide "an income statement addressing the TennCare operations." OmniCare provided this information on the Report 2A.

On OmniCare's Supplemental TennCare Operations Statement (the "Report 2A") for the three months ending March 31, 2003, OmniCare reported $52,736,231 in total revenue, $47,752,952 in total medical and hospital expenses, and administrative expenses of $4,874,413 for a net income of $108,866. However, OmniCare did not prepare the Supplemental TennCare Operations Statement as if OmniCare were still at risk, because it did not include an accrual for IBNR in medical expenses or the related premium accrual in total revenue. Section 2-10.i. of the Contractor Risk Agreement requires all income and expenses related to claims, losses, and premiums for claims with dates of service after July 1, 2002, to be included in the Supplemental TennCare Operations Statement.

Management's Comment:

OCHP concurs with this finding and has taken the appropriate corrective action.

C. Medical Fund Target

Effective July 1, 2002, the Contractor Risk Agreement requires OmniCare to submit a Medical Fund Target (MFT) report monthly. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees medical expenses. Although, estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. OmniCare submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for incurred but not reported expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Fund Target reports.

D. Schedule of Examination Adjustments to Capital and Surplus

Capital and Surplus as reported on the March 31, 2003 NAIC Statement	$7,061,008
Required Statutory Net Worth	6,527,113
Excess Statutory Net Worth	$533,895

Note: Per Statutory Accounting Principles, receivables of $1,050,000 as discussed in paragraph A.2. should have been reported as a non-admitted asset on the March 31, 2003, NAIC quarterly statement. This presentation would have cause OmniCare to report a statutory net worth deficiency of $516,105 ($1,050,000-$533,895). Subsequently, the receivable was collected and therefore an adjustment to current net worth or further regulatory action is not required.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether OmniCare pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1),

and section 2-18. of the Contractor Risk Agreement. The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash of cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "Denied" and specify all known reason for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation.

TDCI has previously requested data files from all TennCare MCOs containing all claims processed during the months of January 2003 and April 2003. The dates of services of claims processed during these two months are of the most relevance to the examination period. Separate files were submitted for medical and pharmacy claim types. Each set of data was tested in its entirety for compliance with the prompt pay requirements of Tenn. Code Ann. Because these tests were performed on all claims processed in January 2003 and April 2003, no projections to the population are needed. Listed below are the results of these analyses:

<u>Medical Results</u>

	Within 30 days	Within 60 days	Compliance

T.C.A. Requirement	90%	99.5%	
January 2003	99.81%	99.99%	**Yes**
April 2003	99.92%	99.98%	**Yes**

Pharmacy Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	100%	100%	**Yes**
April 2003	100%	100%	**Yes**

OmniCare was in compliance with Tenn. Code Ann. § 56-32-226(b) for claims processing requirements in the months of January 2003 and April 2003.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in the testing of OmniCare's claims processing system.

The following items were reviewed to determine the risk that OmniCare had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints on file with TDCI related to accurate claims processing
- OmniCare's monitoring procedures for subcontractors
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy report submitted to TDCI
- Review of the preparation of the claims processing accuracy report
- Review of internal controls (including the testing of those controls by OmniCare)

As noted below, the claims accuracy testing by OmniCare's claims processing subcontractor revealed several deficiencies. Also, as noted in other sections of this report, OmniCare's subcontractor monitoring procedures are not adequate and OmniCare lacks an internal audit function as part of its organizational structure. Therefore, substantive testing was expanded by TDCI. The expanded testing included an on-site visit to Doral,

OmniCare's claims processing subcontractor located in Mequon, Wisconsin. During the on-site visit of Doral, mailroom procedures and the claims payment accuracy report preparation procedures were reviewed, and medical claims were tested.

C. Claims Payment Accuracy Report

Section 2-9. of the Contractor Risk Agreement requires that 97% of claims are paid accurately upon initial submission. OmniCare is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter. Doral, OmniCare's claims processing subcontractor prepares the quarterly claims payment accuracy report.

OmniCare reported the following results for the third and fourth quarters of 2002 and first and second quarters of 2003:

	# of claims tested	Results Reported	Compliance
Third Quarter 2002	348	99.43%	**Yes**
Fourth Quarter 2002	400	99.25%	**Yes**
First Quarter 2003	400	99.00%	**Yes**
Second Quarter 2003	400	99.00%	**Yes**

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with internal control staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter 2003 claims payment accuracy report. This review included verification that the number of claims reviewed constituted an adequate sample to represent the population. In addition, claims were selected at random from the source documentation. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for

mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

The quarterly claims payment accuracy report for the second quarter of 2003 was selected for review. Ten claims were reviewed by TDCI to verify testing accuracy. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected. The following deficiencies were noted during the review of the claims payment accuracy report preparation procedures:

- Doral, OmniCare's claims processing subcontractor prepares the quarterly claims payment accuracy report. This report was not verified by OmniCare. This report should be verified by OmniCare as part of OmniCare's ongoing procedures to monitor Doral's claims processing accuracy.

  Management's Comment:

  OCHP concurs with this statement. Future reporting of the Claims Accuracy Report will be prepared by OCHP and will be a part of the ongoing procedures to monitor Doral's claims processing accuracy.

- Documentation was not maintained supporting the random selection of claims. As a result, the examiners could not verify that the claims tested were randomly selected as required in the section 2-9. of the Contractor Risk Agreement.

  Management's Comment:

  OCHP concurs with this statement. Claims tested for this audit were conducted on a statistically valid random sample, within the defined quarter.
  Audit trails will now be kept and records maintained to support random selection of claims.

- Documentation was not maintained supporting that the total claims population was defined before the claims tested were selected by Doral. As a result, the examiners could not verify that every claim processed in the quarter had an equal opportunity to be selected in order to ensure a statistically valid sample.

  Management's Comment:

OCHP concurs with this statement. The total claims population was defined before the claims tested were selected within the defined quarter. Audit trails will now be kept and records maintained to demonstrate that a statistically valid sample was utilized to ensure that every claim processed in the quarter has an equal opportunity to be selected during the process.

- Pharmacy claims processed by Scripts Pharmacy Solutions, Inc. and vision claims process by Block Vision were not included in the determination of the claims accuracy percentage.

  Management's Comment:

  OCHP concurs with this statement. Separate reports should have been filed for both Pharmacy and Vision. OCHP only submitted the Prompt Pay Analysis for medical claims, for the medical analysis report. Future reporting for the Prompt Pay Analysis will include a separate report for claims accuracy for vision services.

D. Claims Selected For Testing

Based on results from the items reviewed above, 60 claims were selected for testing. OmniCare provided data files of paid and denied claims for the months of January 2003 and April 2003. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From each data file, 30 claims were randomly selected.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of non-compliance within the total population of claims.

To ensure that the January 2003 and April 2003 data files included all claims processed in the month, the total amount paid per each of the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Original hard copy claims were requested for the 60 claims tested.

The required data elements of Attachment XII of the Contractor Risk Agreement were compared to the data elements entered into the claims processing system. One discrepancy was noted. The procedure code reported on one claim tested did not agree with the procedure code entered in the claims system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. Results of the adjudication testing are as follows:

Two claims on the second submission by the provider were incorrectly denied due to untimely filing. The claims were originally submitted within the 120 day timely filing limit. Subsequently, OmniCare paid the claims based on provider appeals of the second denial.

Management's Comment:

OCHP concurs with this statement.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. Results of the price accuracy testing are as follows:

1. The procedure code was incorrectly keyed into the claims processing system for one claim tested resulting in incorrect payment of the claim.

   Management's Comment:

   OCHP concurs with this statement. The coding error was corrected and the claim was adjusted accordingly. Provider and Encounter files have since been corrected.

2. The fee table loaded in the claims processing system was incorrect for four claims tested resulting in the incorrect payment of the claims. OmniCare should perform an audit of the accuracy of all fee tables loaded in the claims processing system.

   Management's Comment:

   OCHP concurs with this finding. Subsequent to this audit, and due to this noted deficiency, OCHP and Doral have implemented several internal weekly crosscheck procedures to ensure precise loading for all fee-tables to reduce keypunch errors. We have also a hired a full-time internal claims auditor that also audits the accuracy of all fee-tables that are loaded in the system.

H. Withhold, Deductible and Co-payment Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. OmniCare's contracts with providers do not apply withhold to provider payments.

2. The purpose of testing deductibles and co-payments is to determine whether enrollees are subject to out-of-pocket payments for certain procedures, whether out-of-pocket payments limits have not been exceeded, and whether out-of-pocket payments are accurately calculated in accordance with section 2-3.i. of the Contractor Risk Agreement. None of the 60 claims tested had enrollees that were required to pay co-payments. Therefore, five claims with enrollees with co-payment requirements were selected for testing. No discrepancies were noted during testing.

I. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and co-payments are provided an explanation of benefits in accordance with usual and customary health care industry practices.

OmniCare provides EOBs to enrollees whose claims are subject to cost sharing. None of the 60 claims tested had enrollees whose claims were subject to cost sharing. Therefore, five additional claims with cost sharing requirements were selected for EOB testing. No discrepancies were noted during the review of EOBs.

J. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the provider accurately reflect the processed claim information in the system.

The remittance advices for the 60 claims tested were requested to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the information communicated to the providers.

K. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to (1) verify the actual payment of claims by OmniCare, and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The cancelled checks for the 60 claims tested were requested. The check amounts agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

L. Suspended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been suspended or pended by OmniCare, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. OmniCare provided the examiners a claims report as of July 31, 2003. OmniCare reported a total of 39,716 pended claims of which none were over 60 days old. There was no indication that a potential unrecorded material liability existed as a result of pended claims because less than one percent of the pended claims were related to the non-risk period which began July 1, 2002.

M. Electronic Claims Capability

Section 2-9.g. of the Contractor Risk Agreement states, "The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment. . . ." Section 2-2.h. of the Contractor Risk Agreement

required MCOs to move to electronic billing. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

OmniCare's claims processing subcontractor has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes. OmniCare's claims processing subcontractor is currently processing claims under these standards for some of their providers.

N. Mailroom Testing

Mailroom procedures at Doral were reviewed. The review included a walk through of the mailroom and discussions with mailroom personnel. Based on the review, controls in the mailroom were adequate. Also, ten claims were selected from a batch of incoming mail on October 20, 2003, to determine if the claims were entered into the claims processing system with correct received date. All ten claims were entered into the claims processing system with correct received date.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

OmniCare maintains a log of all provider complaints. Twenty complaints were selected from OmniCare's complaint log. For the 20 provider complaints selected for testing, 13 (65%) were not responded to within 30 days after the receipt of the complaint per Tenn. Code Ann. § 56-32-226(b)(3)(A).

Management's Comment:

OCHP concurs with this statement. OmniCare's previous policy and procedures were to respond and resolve provider claims appeals/complaints within sixty (60) days of receipt of the complaint. We were informed during the audit that we must notify providers that were

in receipt of the complaint/appeal within thirty (30) days receipt of the complaint/appeal. All provider complaints/appeals were resolved and responded to within the required sixty days. OCHP has since amended its policies and procedures to acknowledge receipt of a provider complaint/appeal within thirty days and will continue to completely resolve all appeals/complaints within sixty (60) days per Tenn. Code Ann.§ 56-32-226(b)(3)(A).

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. No deficiencies were noted in the review of OmniCare's provider manual.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operation documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include but are not limited to; standards of care, assurance of TennCare enrollees rights, compliance with all Federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per section 2-9. of the Contractor Risk Agreement between OmniCare and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, section 2-18. of the Contractor Risk Agreement requires that all provider agreements executed by OmniCare shall at a minimum meet the 44 current requirements listed in section 2-18.

Three provider agreements were selected for testing to determine if they contained all the required minimum language requirement of section 2-18. of the Contractor Risk Agreement. All three agreements failed to meet the minimum language requirements of section 2-18. The results of each deficiency are listed below:

1. TDCI and the Comptroller requested the agreement with Methodist Healthcare, Inc. which represents five hospitals listed in the OmniCare Provider Directory 2003. OmniCare was not able to provide an executed Methodist Healthcare, Inc., agreement based on the provider agreement template previously approved by TDCI. Instead, OmniCare was only able to provide a "Letter of Agreement" executed between OmniCare and Methodist Healthcare Systems in July 2002. This "Letter of Agreement" was not submitted to TDCI as a material modification of OmniCare's certificate of authority. The "Letter of Agreement" notes that it is an interim arrangement with the intent that OmniCare and Methodist Healthcare, Inc., will enter a definitive agreement within 120 days. Additionally, the "Letter of Agreement" indicates the agreement may be terminated immediately by either party upon the other party's material breach of any term or condition. Comparison of language in the "Letter of Agreement" with section 2-18. indicates the Letter of Agreement is deficient in 36 of the current 44 minimum contract language requirements. The continued operation by OmniCare under the unapproved "Letter of Agreement" is contrary OmniCare's certificate of authority.

   The "Letter of Agreement" is missing the following 36 required minimum contract elements:

   d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the CONTRACTOR;

   f. Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient under this Agreement for non-medical reasons, including, but not limited to, failure to pay applicable cost sharing responsibilities. Upon next renewal of provider agreements, the CONTRACTOR shall specify that effective January 1, 2003, the CONTRACTOR may require that a TennCare Standard enrollee pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, until such time that an amendment to the provider agreements are executed, the CONTRACTOR shall include said provisions in the providers administrative manual or other such communications. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

   i. Provide that emergency services be rendered without the requirement of prior

authorization of any kind;

j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that CMS mandates the enforcement of the provisions of CLIA;

k. Require that an adequate record system be maintained for recording services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement). Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records;

l. Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the CONTRACTOR or TENNCARE and authorized federal, state and Comptroller personnel;

m. Provide that TENNCARE, U.S. Department of Health and Human Services, and Office of Inspector General Comptroller shall have the right to evaluate through inspection, whether announced or unannounced, or other means any records pertinent to this Agreement including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records;

n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees sponsored by the CONTRACTOR;

o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the CONTRACTOR and/or TENNCARE;

p. Specify that the CONTRACTOR shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

q. Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

r. Provide for submission of all reports and clinical information required by the CONTRACTOR;

s. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in section 4-21. of this Agreement;

t. Provide the name and address of the official payee to whom payment shall be made;

v. Provide for prompt submission of information needed to make payment;

w. Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in T.C.A. 56-32-226 and Section 2-9.g. of this Agreement;

x. Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus the amount of any applicable cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served;

y. Specify that at all times during the term of the agreement, the provider shall

indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the MCO. This indemnification may be accomplished by incorporating Section 4-19 of the TENNCARE/MCO Agreement in its entirety in the provider agreement or by use of other language developed by the OmniCare and approved by TENNCARE.

z. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the CONTRACTOR under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

aa. Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan;

bb. Provide that the agreement incorporates by reference all applicable federal and state laws, TennCare rules and regulations or court orders, and revisions of such laws or regulations shall automatically be incorporated into the agreement, as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the CONTRACTOR and provider agree to negotiate such further amendments as may be necessary to correct any inequities;

cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

dd. Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4-2 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form,

any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TENNCARE;

ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).

ff. Include a conflict of interest clause as stated in Section 4-7 of this Agreement between the CONTRACTOR and TENNCARE;

gg. Specify the extent to which any savings or loss realized by the plan shall be shared with the providers;

hh. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and CONTRACTOR to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the CONTRACTOR;

ii. Specify that the provider must adhere to the Quality of Care Monitors included in this Agreement as Attachment II;

jj. Specify that a provider shall have at least one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR and no more than one hundred eighty (180) calendar days from the date of rendering a health care service to file an initial claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. At the next renewal or amendment period of the provider agreement, the CONTRACTOR shall specify that a provider shall have at least, but no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the

CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility;

kk. Specify that the provider will comply with the appeal process including but not limited to assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review;

ll. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules, subsequent amendments, or any and all Court Orders;

mm. Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect;

nn. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. A listing of the EPSDT benefit package is contained in Attachment IX of this Agreement. All provider agreements must contain language that references the EPSDT benefit package found in Attachment IX and the agreement shall either physically incorporate Attachment IX or include language to require that the attachment be furnished to the provider upon request At the next renewal or amendment period of provider agreements, this Attachment IX shall be deleted and replaced by the new reference and items found in Section 2-3.u.8 of this Agreement;

oo. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare; and

pp. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater.

qq. All primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) to the BHO for payment.

rr. Require that providers offer hours of operations that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

Subsequently, on February 24, 2004, OmniCare amended the "Letter of Agreement" to correct the deficiencies noted in the examination.

Additionally, nine other hospitals were contracted under this "Letter of Agreement" but as of April 1, 2003, these nine hospitals have complete contracts that meet the required TennCare contract language of Section 2-18.

Management's Comment:

OCHP has submitted to TDCI an amended agreement signed by Methodist Healthcare, which includes the TennCare contract language of Section 2-18. OmniCare has also provided copies of the hospital contracts signed by the new owners of the rural facilities that were sold by Methodist Healthcare. Also, it is not a

violation of the CRA to have a letter of agreement, as long as the agreement contains the required TennCare contract language.

The LOA specifically states: It is anticipated that a Master Agreement shall be approved and executed within 120 days. In the event a Master Agreement has not been executed, the LOA shall automatically renew for successive thirty-day periods unless non-terminating parties are provided with thirty days prior written notice by the terminating party or parties.

All of our agreements/and or contracts require thirty or sixty-day notices for terminating contracts.

TDCI's and Comptroller's Rebuttal:

As of March 31, 2003, the end of the examination period, OmniCare had not submitted the Letter of Agreement as a material modification to its Certificate of Authority. As previously stated the Letter of Agreement did not contain 36 of the minimum required contract elements during the examination period. The required contract elements were not added to

the Letter of Agreement until an amendment on February 24, 2004, which was implemented before it was submitted to TDCI for approval. As noted by OmniCare's comment, the Letter of Agreement anticipates a Master Agreement will replace the Letter of Agreement. As of the release date of this report, a Master Agreement has not been approved and executed.

2. TDCI and the Comptroller requested the agreements with Total Health Care, a primary care provider, and Pediatric Cardiology Consultant, P.C., a specialist provider. Both agreements were executed on a version of the template agreement previously approved by TDCI. Comparison of the current section 2-18. requirements of the Contractor Risk Agreement for both of these contracts indicates they lack the following recent additions in the latest amendments to the Contractor Risk Agreement.

   pp. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater.

   qq. All primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) to the BHO for payment.

   rr. Require that providers offer hours of operations that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

   Management's Comment:

   OCHP concurs with this finding. OCHP has since updated and amended the two deficient contracts with both Providers to include all of the provisions of section 2-18.

D. Subcontractors

During the examination period, OmniCare had subcontracts in place with the following companies: Doral Medical USA, LLC, Script Pharmacy Solutions, Inc. and Block Vision, Inc. The Block Vision and Doral Medical subcontracts were approved by TDCI on May 8, 2001. Script Pharmacy Solutions operated as OmniCare's pharmacy benefits manager

(PBM). OmniCare terminated this contract effective July 1, 2003. At that time the TennCare Bureau assumed responsibility for pharmacy services.

E. Title VI Compliance Testing

Effective July 1996, section 2-24. of the Contractor Risk Agreement required OmniCare to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various OmniCare staff and a review of policies and related supporting documentation, OmniCare was in compliance with the reporting requirements of section 2-24. of the Contractor Risk Agreement.

F. HMO Holding Companies

Effective January 1, 2000, all HMOs that are part of a holding company system were required to comply with Tenn. Code Ann. § 56-11 Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer or health maintenance organization subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section and § 56-11-206(a)(1)." OmniCare has complied with this statute.

G. Stabilization

Section 2-2.s. of Amendment 2 of OmniCare's Contractor Risk Agreement requires OmniCare to comply with the following:

> "Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as they existed on April 16, 2002, unless otherwise directed or approved by TennCare…"

Additionally, section 3-10.h.5. of Amendment 2 of OmniCare's Contractor Risk Agreement states:

> "In the event TENNCARE determines a cost was not incurred in accordance with this Agreement, TENNCARE reserves the right to disallow said cost and reduce the amount of future fixed administrative fee payments by the amount of the disallowance."

No items were noted during the examination that indicated noncompliance with stabilization requirements.

H. Lack of Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

During the examination of OmniCare, it was noted that OmniCare lacks an internal audit function as part of OmniCare's organizational structure. As previously noted, OmniCare received TennCare premium revenues of $185,140,878 for calendar year 2002 and $53,665,281 for the period January 1, 2003, through March 31, 2003. The significant amount of premiums received would warrant the employment of at least one internal auditor by OmniCare. Also, the examination has discovered significant deficiencies which possibly could have been avoided with a properly functioning internal audit department. These deficiencies include: incorrect fee tables loaded into the claims processing system, lack of monitoring of subcontractors, and failure to abide by provider letters of agreement.

Management's Comment:

OCHP does not concur with this statement. OCHP has an internal audit function. OCHP did not have an internal claims auditor. The review and evaluation of the accuracy of OCHP's financial record keeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations are part of our daily operational and management activities. OCHP's Finance Department has several employees on staff that perform these duties daily. While we did not have an **"Internal Auditor"** with this exact title that operates independently and separate from the budget analysts, managers and CPAs within the department, does not

mean that these functions are not performed.

1. This statement implies that we have failed to provide due diligence in our financial responsibilities, which is false. A quote **"internal auditor"** indeed helps to ensure a greater percentage of accuracy and reduces mistakes; however it does not by title, prevent errors or mistakes. The deficiencies noted in this report are just that, errors and mistakes, regarding which we will continue to improve our processes to correct and or ameliorate.

TDCI's and Comptroller's Rebuttal:

As previously mentioned, the examination discovered deficiencies which possibly could have been avoided with a proper internal audit function. The internal audit function accomplished either by an internal auditor or audit department, should report directly to the board of directors and the appropriate level of management so the auditor or department can maintain its independence and objectivity.

I. Monitoring of Subcontractors

The Contractor Risk Agreement permits OmniCare to subcontract duties but OmniCare is ultimately responsible for ensuring that these duties are performed in compliance with the Contractor Risk Agreement and statutory requirements.

As previously reported OmniCare has subcontracted with Doral USA, LLC, to process medical claims submitted by medical providers. OmniCare needs to improve the monitoring efforts of its major subcontractor for claims processing services. Specifically, OmniCare relies solely on Doral to report claims payment accuracy without confirmation or sampling for accuracy by OmniCare. Additionally, OmniCare personnel have only limited access to Doral's clams processing system. This limited access is insufficient to monitor and test the claims processing efforts by Doral. As previously mentioned, TDCI was required to expand testing to include an on-site visit of Doral in Mequon, Wisconsin, because of OmniCare's limited access to Doral's claims processing system.

Subsequently, management has indicated in response to another finding that OmniCare will prepare future Claims Accuracy reports.

Management's Comment:

OCHP concurs with this statement. At the time of the audit, OmniCare did not have the ability to show the auditors, specifically "adjustments" to claims. OmniCare has complete access to claims data; and since the time of this audit, has gained the ability to view all claims adjustments.

OCHP diligently monitors the activities of Doral (subcontractor). Moreover, OCHP has in place various processes and procedures, including a Delegated Oversight Committee; conducts annual site visits; daily monitoring of claims data, in conjunction with other provisions within our MIS Department, medical management, provider services and contracting departments to ensure that claims are processed in accordance with our business rules, polices and procedures. A copy of the annual site review was forwarded to your office before the final draft of this report was written. OCHP is responsible for the administration and management of all aspects of the CRA and our health plan, which includes all subcontractors acting on behalf of the Plan.

OCHP concedes that we need to improve the monitoring efforts of this subcontractor and that an internal claims auditor was needed to ensure better oversight of claims processing procedures by Doral as well as the preparation of the Claims Payment Accuracy Report. Both deficiencies have been duly noted and addressed. An internal claims auditor was hired and the claims accuracy report is now prepared by OCHP Finance & Administration.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of OmniCare.